

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2013
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NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/18/13</p> <p>Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Coventry Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a</p>	K010000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. This facility respectfully requests a revisit on or after December 18, 2013.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>capacity of 150 and had a census of 136 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/20/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 2 of 2 Therapy room doors protecting corridor openings. This deficient practice could affect 5 residents in the Therapy room and any resident near the main nurses' station.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 11/18/13 at 1:00 p.m., the corridor doors to the Therapy room were propped open with dumbbell weights. This was acknowledged by the Environmental Supervisor.</p> <p>3.1-19(b)</p>	K010018	<p>K 018 NFPA 101 Life Safety Code StandardIt is the practice of this facility to ensure that all doors protecting corridor openings are provided with positive latching hardware and are not propped open. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The dumbbells that were propping open the corridor doors to the Therapy room have been removed.The dumbbells were removed on 11/18/2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents that use the Therapy room have the potential to be affected by the alleged deficient practice.All corridor doors were checked to ensure nothing is propping them open by Maintenance Director.The doors were checked prior to December 18th to ensure they are not propped open. What measures will be put into place or what systemic changes will you make</p>	12/18/2013	

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			to ensure that the deficient practice does not recur: The Maintenance Director or Designee will check all corridor doors on a daily basis to ensure they are not propped open. The Maintenance Director/Designee will in-service all managers to monitor corridor doors to ensure they are not propped open. In-service will be completed by 12/18/13. The Maintenance Director is in charge of program compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring tool called Corridor Doors will be utilized every week x 4, monthly x 3 and quarterly x 2. Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedures may result in disciplinary action up to and including termination. Completion Date: 12/18/2013	

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors entering the biohazard room, a hazardous areas, self closed and latched into the door frame. This deficient practice could affect any of the 25 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 11/18/13 at 12:05 p.m., the corridor door to the biohazard room failed to latch into the door frame. Based on an interview with the Environmental Supervisor at the time of observation, the barrels of soiled linen are stored in the biohazard room until they are taken to the laundry room.</p> <p>3-1-19(b)</p>	K010029	<p>K 029 NFPA 101 Life Safety Code StandardIt is the practice of this facility to ensure all hazardous areas enclosed with doors that are self closing. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The biohazard door on 400 hall will be repaired on or before December 18, 1013 to ensure it latches into the frame. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice.All biohazard doors were checked on or before December 18th to ensure they all latch into the frame. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The biohazard door on 400 hall will be repaired on or before December 18, 1013 to ensure it latches into the frame.All</p>	12/18/2013	

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			<p>biohazard doors will be monitored by the Maintenance Director/Designee on an on-going basis to ensure they latch into the frame. The Maintenance Director/Designee will in-service Maintenance Assistant on biohazard doors self closing and latching into the frame by December 18, 2013. The Maintenance Director is in charge of program compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring tool called Biohazard Doors will be utilized weekly x 4 and every month x 3 and quarterly x 2. Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>Non-compliance with facility procedures may result in disciplinary action up to and including termination. Completion date: 12/18/2013</p>		

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K010044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 8 fire door sets were arranged to automatically close and latch. LSC requires 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect 3 of 8 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observations with the Environmental Supervisor and the Maintenance Supervisor on 11/18/13 at 12:00 p.m. and then at 1:25 p.m., the 400 hall fire door set near resident room 415 and the fire door set near the conference room did not latch into the frame. Based on an interview with the Environmental Supervisor at the time of observation, the building is continually settling which creates latching problems with the fire doors.</p>	K010044	<p>K 044 NFPA 101 Life Safety Code StandardIt is the practice of this facility to ensure all fire door sets are arranged to automatically close and latch. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The fire door sets on 400 hall and near the conference room were fixed on or before December 18, 2013 to ensure they latch into the frame. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice.All fire door sets will be checked by maintenance staff on or before December 26, 2012 to ensure they latch into the frame automatically. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: The fire door sets on 400 hall and near the conference room were fixed on or before December 18, 2013 to ensure they latch into the frame.All fire door sets will be monitored on an on-going basis</p>	12/18/2013			

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	3.1-19(b)		to ensure they latch into the frame automatically by the Maintenance Director/Designee. The Maintenance Director/Designee will in-service Maintenance Assistant on the fire door sets and the that they latch automatically by December 28, 2013. The Maintenance Director is in charge of program compliance How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring tool called Fire Door Latching will be utilized weekly x 4, monthly x 3 and quarterly x 2. Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedures may result in disciplinary action up to and including termination. Completion date: 12/18/2013		

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K010062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to replace the corroded sprinkler heads in 1 of 1 kitchen dish rooms. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice was not in a resident care area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor and the Maintenance Supervisor on 11/18/13 at 1:31 p.m., the two sprinkler heads in the kitchen dish room were corroded with a green substance. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010062	<p>K 062 NFPA 101 Life Safety Code Standard It is the practice of this facility to ensure the sprinkler heads are not corroded. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The sprinkler heads in the kitchen dish room will be replaced on or before December 18th, 2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All residents and kitchen staff have the potential to be effected by the alleged deficient practice.All sprinkler heads will be checked by maintenance staff on or before December 18, 2012 to ensure they are not corroded. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur All sprinkler heads will be monitored on an on-going basis to ensure they are not corroded by the Maintenance Director/Designee.The</p>	12/18/2013			

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			Maintenance Director/Designee will in-service Maintenance Assistant on the sprinkler head locations and monitoring by December 18, 2013. The Maintenance Director is in charge of program compliance How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring tool called Sprinkler Head Inspection will be utilized monthly x 3 and quarterly x 2. Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination. Completion date: 12/18/2013		

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K010076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 11 oxygen cylinders in the oxygen storage room were properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b)27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor and the Maintenance Supervisor on 11/18/13 at 1:55 p.m., there were two unsupported "E" cylinders of compressed oxygen in the oxygen storage room. This was acknowledged by the Environmental Supervisor and the Maintenance Supervisor at the time of observation.</p>	K010076	K 076 NFPA 101 Life Safety Code StandardIt is the practice of this facility to ensure all oxygen cylinders are properly restrained. However based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 2 of the 11 cylinders were immediately restrained on 11/18/2013. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be effected by the alleged deficient practice.All oxygen cylinders will be checked by maintenance staff on or before December 18, 2013 to ensure they are restrained. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All	12/18/2013			

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	3.1-19(b)		oxygen cylinders were checked to ensure they are restrained and will be monitored by maintenance staff on an on-going basis. The Maintenance Director/Designee will monitor daily to ensure the oxygen cylinders are properly restrained. The Clinical Education Coordinator will in-service all nursing staff and managers on how to restrain oxygen cylinders. In-servicing will be completed on or before 12/18/2013. Maintenance Director is responsible for program compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring tool called Oxygen Cylinder Restraint will be utilized weekly x 4, monthly x 3 and quarterly x 2. Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedures may result in disciplinary action up to and including termination. Completion date: 12/18/2013		

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident in the main dining room which usually seats 40 residents or more.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor and the Maintenance Supervisor on 11/18/13 at 11:58 a.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. The rolling fire door was not in a corridor wall. Based on interview with the Maintenance Supervisor at 1:30 p.m., the rolling fire</p>	K010130	<p>K 130 NFPA 101 MiscellaneousIt is the practice of this facility to ensure the rolling fire door receives an annual inspection. However, based on the alleged deficient practice the following was implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The rolling fire door was inspected by IEI, inc. on 11/19/2013 to ensure proper operation and full closure. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents in the dining room have the potential to be affected by the alleged deficient practice. The rolling fire door was inspected by IEI, inc. on 11/19/2013 to ensure proper operation and full closure. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: The rolling fire door will receive an annual inspection by IEI, Inc. The Maintenance Director/Designee will in-service maintenance assistant on scheduling the annual inspection and ensuring it is completed. In-service will be completed on or before December 18, 2013. The</p>	12/18/2013			

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	door did not receive an annual inspection. 3.1-19(b)		Maintenance Director is in charge of program compliance How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring tool called Rolling Fire Door Inspection will be utilized annually.Data will be collected by Maintenance Director/Designee and submitted to the CQI Committee. If threshold of 100% is not met, an action plan will be developed.Non-compliance with facility procedure may result in disciplinary action up to and including termination. Compliance date: 12/18/2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/18/2013	
NAME OF PROVIDER OR SUPPLIER COVENTRY MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring to provide power for medical equipment or equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care area but could affect maintenance staff.</p> <p>Findings include:</p> <p>Based on observation and interview with the Environmental Supervisor and the Maintenance Supervisor on 11/18/13 at 11:30 a.m., the Environmental Supervisor acknowledged a refrigerator and microwave were supplied electricity by an extension cord power strip in the maintenance office.</p> <p>3.1-19(b)</p>	K010147	<p>K 147 NFPA 101 Life Safety Code StandardIt is the practice of this facility to ensure flexible cords are not used as a substitute for fixed wiring. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The flexible cord in the maintenance office was removed immediately. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the alleged deficient practice.All electronic devices were checked on or before December 18th, 2013 throughout the facility by the Maintenance Director/Designee to ensure they are not using flexible cords as a substitute for fixed wiring. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur The flexible cord in the maintenance office was removed on or before December 18, 2003.All electronic devices were checked on or before December 18th, 2013 to ensure they are not using flexible</p>	12/18/2013			

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			<p>cords as a substitute for fixed wiring. The Maintenance Director/Designee will in-service all staff on the prohibited use of flexible cords as a replacement for fixed wiring by December 18, 2013. The Maintenance Director is in charge of program compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring tool called Flexible Cords will be utilized weekly x 4 and every month x 3 and quarterly x 2. Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold of 100% is not met, an action plan will be developed.</p> <p>Non-compliance with facility procedures may result in disciplinary action up to and including termination. Completion date: 12/18/2013</p>		